Comprehensive Community Mental Health Services for Children and Their Families Program

Evaluation Findings: Executive Summary Report to Congress 2009

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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The Comprehensive Community Mental Health Services for Children and Their Families Program

2009 Congress Report

Executive Summary

The Comprehensive Community Mental Health Services for Children and Their Families Program, also known as the Child Mental Health Initiative (CMHI), is a cooperative agreement program operating under the auspices of the Child, Adolescent and Family Branch (CAFB) in the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services. The CMHI was authorized by legislation (Public Law 102-321) and provides funds to public entities to promote transformation of the mental health care system that serves children and youth (aged 0–21 years) diagnosed with a serious emotional disturbance and their families.

Children and adolescents with serious emotional disturbance face challenges in many aspects of their daily lives. They are at greater risk for substance abuse disorders (CMHS, 2002; Holden, 2003; Holden et al., 2003; Liao, Manteuffel, Paulic, & Sondheimer, 2001; Substance Abuse and Mental Health Services Administration, 2002) and negative encounters with the juvenile justice system (CMHS, 2002; Davis & Vander Stoep, 1997). Students with emotional disturbance fail more courses, earn lower grade point averages, miss more days of school, are retained at grade more than students with other disabilities, and have high dropout rates (Epstein, Nelson, Trout, & Mooney, 2005; U.S. Department of Education, 2001). Research by Friedman, Kutash, and Duchnowski (1996) further supports assertions for poor long-term outcomes for these children and adolescents, indicating a significant correlation between childhood emotional disorders and problems in adulthood. Services that exist to address these issues are often inconsistent; they are often provided by a variety of professionals who work in diverse, relatively independent, and loosely coordinated public and private facilities, agencies, and systems often referred to as the *de facto mental health service system* (U.S. Department of Health and Human Services, 1999). Therefore, families are challenged with obtaining services, and children and youth are left at risk for difficulties in school and/or in the community.

CMHI funding is provided to develop and implement systems of care in States and territories, local communities, and American Indian and Alaska Native communities. The system of care approach is predicated upon eight guiding principles for service provision:

- Family driven
- Individualized, strengths-based, and evidence-informed service plans
- Youth guided
- Culturally and linguistically competent
- In the least restrictive environment possible
- Community based
- Accessible

- Through a collaborative and coordinated interagency network

Accordingly, services should be both comprehensive and coordinated among public and private providers, consumers, and other key constituents. CMHI-funded systems of care build on the individual strengths of participating children, youth, and families to address their service needs. They also aim to reduce service disparities by promoting cultural and linguistic competence and responsiveness.

The program has grown since its inception in 1993 from initial funding of $4.9 million to a total investment of approximately $1.4 billion as of fiscal year (FY) 2009, awarding 164 grants and cooperative agreements to communities. Seven cohorts (phases) of grants/cooperative agreements have been awarded since 1993. For simplicity, CMHI-funded system of care sites are referred to in this summary as "grant communities" regardless of whether they were funded by grants or cooperative agreements. Communities initially funded from FY 1993 to FY 2003 have completed their funding and are now considered "alumni communities." Phase IV grant communities funded in FY 2004 and Phase V grant communities funded in FY 2005 and FY 2006 are in their latter years of funding. Phase VI and Phase VII grant communities began to receive funds in FY 2008 and FY 2009, respectively.

The legislation authorizing the CMHI also mandated a national evaluation to describe, monitor, and chronicle the initiative's progress. The national evaluation consists of multiple studies designed to examine the effectiveness of the CMHI at different levels, including descriptive, longitudinal, system-level, cost, and special studies.

The 2009 *Report to Congress* presents findings based on the national evaluation of 59 CMHI grant communities funded in FYs 2002–2006 (Phases IV and V). Descriptive data were collected from 24,524 children enrolled in these CMHI grant communities. Longitudinal data were collected from 7,533 caregivers and 4,061youth aged 11 years and older. Analyses of the longitudinal data are based on data from youth or caregivers who completed all four follow-up interviews. Sample sizes for different analyses vary, as not all caregivers responded to all items.

The 2009 *Report to Congress* describes

- the system of care approach, in particular the CMHI;
- the characteristics, outcomes, and service experiences of the children, youth, and families receiving services through the CMHI;
- the implementation of the system of care philosophy;
- the resources used by CMHI communities.

Description of the Children, Youth, and Families

CMHI grant communities serve a diverse group of traditionally underserved children and youth. Demographic characteristics of those served by Phase IV and V communities include

- 62.9 percent were male (compared to 51.2 percent of the U.S. population);
- 59.7 percent belonged to non-White racial and ethnic groups (compared to 42.3 percent of the U.S. population);
- 49.1 percent lived with their biological mother only (compared to 23.1 percent of children and youth aged 0–17 years in the U.S. population), and another 25.7 percent lived with both biological parents (compared to 69.4 percent of children and

youth aged 0–17 years in the U.S. population); and
- 57.6 percent lived in poverty (as defined by the U.S. Census Bureau, compared to 17.2 percent of all children and youth aged 0–17 years in the U.S. population).

Many of these children and youth lived in family situations that put them at greater risk for later mental health challenges, including being exposed to domestic violence (46.7 percent), living with an adult who had been convicted of a crime (34.2 percent), having a biological family member with mental illness (85.2 percent), or experiencing physical abuse (22.4 percent).

The Phase IV and V systems of care were successful in engaging multiple community agencies. About one-quarter (24.9 percent) of the children and youth were referred to CMHI services by a mental health agency, clinic, or provider. Other community agencies also were responsible for referrals: schools (21.1 percent), child welfare agencies (15.4 percent), and juvenile justice offices (11.3 percent). Self-referrals by caregivers accounted for 10.7 percent of referrals.

Most children and youth (77.3 percent) participated in their own service planning meetings, along with caregivers and other family members. Mental health case managers participated in 76.3 percent of service planning meetings. Representatives of community agencies involved with the children, youth, and families participated to a lesser degree: education (16.8 percent), child welfare (11.9 percent), juvenile justice (8.7 percent), and primary health care (3.8 percent).

Child, Youth, and Caregiver Outcomes

Children and youth exhibited a range of problems when entering the system of care:

- Conduct or delinquency-related problems (57.0 percent)
- Hyperactive and attention-related problems (37.7 percent)
- Depression-related problems (35.0 percent)
- School performance problems (32.5 percent)
- Adjustment-related problems (31.9 percent)
- Anxiety-related problems (28.1 percent)
- Suicide-related problems (including ideation, attempt, and self-injury) (16.3 percent)

Twenty-four months after enrollment in CMHI services, children and youth demonstrated a variety of improved clinical and functional outcomes. Many caregivers (40.3 percent) reported that their children's overall behavioral and emotional strengths had increased, and 47.7 percent reported that their children exhibited decreased maladaptive behavioral and emotional symptoms. In fact, the percentage of children and youth aged 6–18 whose behavioral and emotional problems were in the clinical range dropped from 83.1 percent at intake to 62.5 percent after 24 months.

In addition, many youth aged 11 and older (23.3 percent) reported that they experienced fewer symptoms of depression, and 30.7 percent reported fewer symptoms of anxiety. The percentage of caregivers reporting that their children and youth had contemplated attempting suicide during the previous 6 months fell from 29.0 percent at intake to 14.0 percent at 24 months. Similarly, the percentage of caregivers reporting their

children had attempted suicide in the previous 6 months fell from 9.4 percent at intake to 2.8 percent at 24 months.

Only about one-quarter (27.6 percent) of caregivers reported that their children's general functional impairment had decreased. However, children and youth showed more substantial improvements in specific types of home and community functioning 24 months after enrollment in the CMHI:

- Regular school attendance (attending at least 80 percent of the time) improved from 82.4 percent to 89.8 percent.
- Missing school due to behavioral or emotional problems decreased from 77.2 percent to 63.4 percent.
- Missing daycare or afterschool programs due to behavioral or emotional problems decreased from 36.7 percent to 19.6 percent.
- Maintaining a single, rather than multiple, living situation in the previous 6 months increased from 70.9 percent to 81.7 percent.
- Being arrested (as reported by youth aged 11 and older) decreased from 18.0 percent to 8.0 percent.
- Engaging in any delinquent behavior (as reported by youth ages 11 and older) decreased from 77.0 percent to 46.4 percent.

Caregivers reported improved outcomes as well:

- Almost half (46.4 percent) of caregivers reported decreased levels of strain associated with caring for their children.
- Employed caregivers reported missing 6.9 days of work on average in the 6 months prior to intake. In contrast, at 24 months after intake, employed caregivers reported missing only 3.1 days of work on average in the previous 6 months.

Services Received, Their Associated Costs, and Caregivers' Service Experiences

CMHI systems of care provide a variety of services, including assessment; medication monitoring; individual, group, and family therapy; case management; therapeutic foster care or group home; residential therapeutic camp or wilderness program; and vocational training. Although many children and youth experienced several different types of services during the first 12 months after intake (8.4 different types of services on average per child or youth during that time period), the number decreased to 6.9 types of services between the 12- and 24-month interviews per child, on average.

Decreased inpatient hospital care of children and youth in the first 24 months after intake resulted in a maximum estimated gross savings of $25.6 million. This estimate assumes that all children and youth served by CMHI communities during FY 2009 might receive inpatient hospital care some time during the first 24 months after entering CMHI services. A decrease in the number of arrests of youth aged 11 and older in the first 24 months after intake resulted in a maximum estimated gross savings of $4.2 million. Similarly, this estimate assumes that all youth aged 11 years and older who were served by CMHI communities during FY 2009 might be arrested within their first 24 months after entering CMHI services.

Satisfaction with the range of services provided by grant communities is vital to child, youth, and family participation in services. Caregivers' perceptions about their satisfaction with services and their outcomes are also critical to meet the authorizing legislation's mandate to have parents assess

the effectiveness of systems of care. Caregivers and youth were very satisfied with the services they received through the CMHI, as well as with the outcomes of those services. In addition, caregivers and youth found their service providers to be culturally competent and culturally sensitive. Also of note is that caregivers were more satisfied with services and outcomes when clinicians provided them with information about the treatment their children were receiving, including the amount of experience the provider had with a particular treatment and the research support for the use of that treatment.

System-Level Assessment of the CMHI

National evaluation results are used to strengthen program efforts at all levels and shared with the Federal program, communities, and technical assistance providers. Four studies contribute data to the assessment of the system-level effectiveness of the CMHI:

- The *System of Care Assessment* (exploring how communities implement the system of care principles over the course of their CMHI funding).
- The *Sustainability Study* (examining how grant communities prepare and continue to sustain system of care infrastructure and services after CMHI funding ends).
- The *Evidence-Based Practices Study* (examining the effects of various factors on the implementation of EBP in system of care sites funded in FYs 2005 and 2006).
- The *Primary Care Provider Study* (examining how physicians interacted with systems of care to improve mental health care for children and families).

Findings from these studies indicate that grant communities tend to be increasingly successful over the course of their funding in implementing the eight guiding principles of system of care. Further, grant communities achieved a variety of goals aimed at increasing system of care sustainability beyond CMHI funding. In particular, successes reported by grant communities included reducing the number of children served in more restrictive settings and minimizing the need for children and youth to leave the community in order to obtain services.

Opportunities for improvement in effecting system-level change remain, however. Areas reported by community leaders as needing additional attention include ensuring that services have sufficient capacity, creating an advocacy base and mobilizing resources, making certain that service providers attain a better understanding of how to implement evidence-based practice, and fostering better communication and stronger links between primary care and mental health care providers.

In the *Primary Care Provider Study*, pediatricians noted some of the barriers they have faced when connecting children and youth to mental health services, and provided suggestions for how to eradicate those barriers. These suggestions included ensuring insurance reimbursement for services; increasing the number of providers; increasing funding for training; and educating children and youth, their families, and their communities about the mental health needs of children and youth.

Finally, the Evidence-Based Practices Study revealed that mental health providers were interested in implementing evidence-based treatments (EBTs) and recognized their benefit to children and youth. They also noted several concerns with fitting the use of EBTs into the concept of individualized care, but many of these concerns can be

allayed with additional education and training.

Conclusions

Results from the national evaluation of the CMHI indicate that gains were made by children, youth, and families in clinical outcomes and general functioning. National evaluation data also indicate that CMHI grant communities are

- reaching many children typically underserved by the mental health system;
- improving outcomes for children;
- enhancing family outcomes;
- expanding the availability of effective supports and services;
- continuing to implement and maintain fidelity to system of care principles;
- developing and successfully using sustainability strategies.

As in any system transformation effort, CMHI grant communities face challenges in sustaining their efforts and effecting broad system-level changes, including building a culturally and linguistically competent workforce, addressing challenges to cross-agency collaboration to support an efficient multi-agency structure that serves the needs of children and families, and implementing multiple strategies for sustaining systems of care over time. Despite these challenges, CMHI-funded communities continue to move forward in developing and implementing appropriate and tailored services and supports for children, youth, and their families.

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